Health Care for Women International, 23:163–172, 2002
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0739-9332/02 $12.00 + .00

SOCIAL FACTORS THAT MAKE SOUTH AFRICAN WOMEN VULNERABLE TO HIV INFECTION

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The degree to which women are able to control various aspects of their sexual lives is clearly a critical question for health promotion and the prevention of AIDS. It is evident that social factors such as the high rate of rape, the unfavourable economic position of women, and the inability to insist on condom usage make South African women unable to negotiate the timing of sex and the conditions under which it occurs. They are thus rendered powerless to protect themselves against HIV infection. Prevention campaigns often do not take into account the reality of the daily lives of South African women and the difficulties they face gaining control over their own sexual lives. The rampant spread of this disease can only be stemmed if the subordinate position of women is acknowledged and addressed.

HIV infection in South Africa, as in the rest of Sub-Saharan Africa, has become a source of national concern. After many prevention campaigns and education programs the virus continues to spread at an alarming rate, forcing one to look more carefully at the underlying social organization that could be conducive to the spread of this disease. In particular the position of women is being investigated in order to uncover the social dynamics that increase their vulnerability to this disease.

HIV/AIDS IN SOUTH AFRICA

With the diagnosis of the first case of AIDS in South Africa in 1982, the pandemic was also recognised in South Africa. In the beginning, South

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Africa followed a typical type 1 pattern,[1] as up to and including 1986 87% of all reported AIDS cases in South Africa were homosexual and bisexual males (Van Rensburg, Fourie, & Pretorius, 1992). However, this picture changed dramatically as more and more heterosexual cases were reported. Today the HIV scenario in South Africa displays, like the rest of Sub-Saharan Africa, a typically heterosexual pattern of transmission (Anderson, 1993; Manuh, 1998).

It is estimated that about 4.2 million people in South Africa are living with HIV/AIDS; this translates into about 19.9% of the entire adult (15–49 years) South African population (UNAIDS, 2000). With 1,600 new infections per day (over half a million people per year) the disease will have devastating economic, social, and demographic effects on this country (Kruger, 1999). Leaders in the field estimate that the life expectancy in South Africa will drop to in the forties in 10 years and that by 2005 one in five workers could be HIV positive (Hasenfuss, 1999).

SOUTH AFRICAN WOMEN AND HIV INFECTION

Data concerning HIV seroprevalence among South African women is mainly collected during screening at antenatal clinics. Since 1990 a yearly survey of pregnant women at antenatal clinics of the public health services were conducted. These surveys form the cornerstone of HIV surveillance in South Africa. After the first democratic elections in 1994, the survey was adapted to reflect the new provincial structure of the country.[2]

From the outset, the purpose of this surveillance was to collect a geographically representative sample of blood specimens in order to monitor the progress of the epidemic. An advantage of these surveys is that women attending these clinics are regarded as being reasonably representative of the fertile, sexually active South African population (Coleman & Wilkinson, 1997).

Table 1 reflects the latest available figures (for 1998) obtained from the above-mentioned survey. These figures reveal that at the end of 1998, almost a quarter (22.8%) of South African women attending antenatal clinics were HIV positive. This figure was as high 32.5% in the province of Kwazulu-Natal.

With an estimated vertical transmission rate of 30%–50% (Mwale & Burnard, 1992), the above figures do not augur well for the health and well-being of South African infants: Those who do not die from HIV in the first years of life face the possibility of being orphaned.

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[1]The type 1 pattern refers to the spread of HIV mainly by means of homosexual contact and transmission due to the use of unsterile needles in intravenous drug abusers. It is typical of Western societies and is therefore also known as the "Western pattern."

[2]South Africa is currently divided into nine provinces, each with its own provincial government.

Table 1. Percentage of pregnant women attending public antenatal clinics who are HIV positive

Provinces	Year				
	1994	1995	1996	1997	1998
Western Cape	1.20	1.70	3.10	6.30	5.20
Eastern Cape	4.50	6.00	8.10	12.60	15.90
Northern Cape	1.83	5.30	6.50	8.60	9.90
Free State	9.20	11.00	17.50	20.00	22.80
Kwazulu-Natal	14.4	18.20	19.90	26.92	32.50
Gauteng	6.40	12.00	15.50	17.10	22.50
Mpumalanga	12.10	18.30	15.80	22.60	30.00
Northern Province	3.00	4.90	8.00	8.20	11.50
North-West Province	6.70	8.30	25.10	18.10	21.30
South Africa	7.6	10.4	14.2	16.1	22.8

Sources: AIDS Analysis Africa: Southern Africa Edition, 1998 and "Zuma maak vigs 'n aanmeldbare siekte [Zuma makes AIDS a notifiable disease]," 1999.

Regarding age-specific prevalence for women in South Africa, the 1998 antenatal survey revealed that women in the 20–29-year-old category are at greatest risk, as they account for 53% of all cases in this particular survey. What is also particularly worrisome is the increase in the prevalence rates of female teenagers (between the ages of 15 and 19 years) who, in 1998, made up 21% of all cases (this figure was only 12.1% for 1997) ("Zuma maak vigs 'n aanmeldbare siekte, [Zuma Makes AIDS a Notifiable Disease]" 1999).

WOMEN AT RISK

It is clear that HIV currently poses one of the biggest health threats to South African women. Because it is a sexually transmitted disease (STD), we must investigate the factors that make women unable to practice "safe sex." This inevitably brings us to the position of women in society, as the very factors that predispose African women to poverty, malnutrition, and uncontrolled fertility also increase their risk of acquiring HIV infection.

In South Africa, as in many other parts of the developing world, women are born into inequity characterized by low social status. While lower status differs in detail and degree from country to country it has the effect of restricting women's ability to protect themselves from STDs and thus HIV infection (Mwale & Burnard, 1992).

In the past most HIV education campaigns have focussed on the following methods for preventing infection: using condoms, abstaining from sex, and staying faithful to one partner. The problem with these campaigns is that

they fail to take into the account the reality of women's lives and the special risk factors that make them vulnerable.

The risk of women can be divided into two categories: physical and social. We will briefly refer to the physical category and then concentrate on some of the social aspects that make women vulnerable.

PHYSICAL FACTORS

Physiologically, women appear to be at greater risk of contracting HIV than men (Strebel, 1993). It has been found that men appear to pass on HIV more efficiently than women, making a woman twice as likely to be infected by an HIV positive man than a man to be infected by an HIV positive woman (Mwale & Burnard, 1992; Strebel, 1993). Women are more susceptible to most STDs because of the greater mucosal surface exposed to pathogens during sexual intercourse, particularly young girls whose genital tracts are not fully mature (Hoffman, de Pincho, & Cooper, 1998; UNAIDS, 2000).

In addition to this, it is more difficult to identify STDs in women than men and they thus often go untreated, which leads to chronic infections and long-term complications (Hoffman et al., 1998; Strebel, 1993). Researchers have estimated that one quarter of South Africa's sexually active population may have at least one STD (Key, DeNoon, & Boyles, 1997). The consequences for women of this high rate of STDs includes: increased levels of infertility, increased incidences of cervical cancer, and an increased risk of HIV infection (Hoffman et al., 1998; Strebel, 1993). Women are thus physiologically more vulnerable to infection.

SOCIAL FACTORS

Apart from the physiological vulnerability of women it is important to consider the social aspects that put women at risk. This section outlines some of the social factors that make South African women vulnerable to HIV infection. One factor often influences the other.

Violence against Women

"The Global Report on Women's Human Rights" states that violence against women is a leading cause of female injury in almost every country in the world and is typically ignored by the state or only erratically punished (Mohapeloa, 1995). Gender violence is widely recognized as being a big problem in South Africa, yet the exact levels of gender violence in South Africa are not known. This is partly because this type of violence is often not reported. However, the information gained about gender violence comes from a number of smaller research projects and from police statistics, and these indicate very high levels (Penn-Kekana, 1997).

If we look at rape as a form of gender violence, it remains one of the least notified crimes in South Africa. The rates of rape in South Africa are

considered to be of the highest in the world and appear to be increasing every year. It is estimated that only 2.8% of rapes are reported, bringing the total rapes to about one million a year ("Human Rights Watch," 1995). This is a shocking thought if one considers the possibility of contracting HIV. Another insidious face of this crime is rearing its head in the form of child rape. An in-depth investigation has revealed that the popular myth that "sex with a virgin" will cure AIDS is the root of the recent upsurge in child rapes (the rape of children under the age of eight years). This is particularly the case in the Kwazulu-Natal Province (Govender, 1999).

Penn-Kekana (1997) states that violence in intimate relationships occurs often, so often in fact that it has come to be perceived as almost normative and to a large extent accepted rather than challenged. Gender violence, often perpetrated by close male partners, is increasingly recognized internationally to be a common feature of adult women's daily experiences (Wood, Jewkes, & Maforah, 1997). A study by a South African university (the University of the Witwatersand) revealed that more than 60% of South African women are regularly battered by boyfriends and husbands (Ramsay, 1995). It has also been estimated that 50%–60% of all marriages involve physical and sexual violence (Penn-Kekana, 1997).

Violence is not limited to the marital relationship, however; it also occurs at an earlier stage in the relationship (boyfriend/girlfriend phase). A study among teenagers in Khayelitsha in the Western Cape Province revealed that in most cases men used violent strategies at the beginning of a relationship, forcing the girl to have sex with them (Wood et al., 1997). The aforementioned authors also mention that other studies have also indicated that 30% of young girls' first sexual encounter were forced.

In addition to the initial forced contact, men were reported to continue using physical assault to enforce contact, beating their partners if they refused to have sex, which is the main reason why the girls continued to have sex (Wood et al., 1997). The aforementioned study also found that men beat their partners if they were seen talking to other men. In some cases control over women was reinforced by brutal means: Gang rape of adolescent girls by friends of the male partner is reported to occur in the community as a way of punishing girls for actual or suspected infidelity. Apart from other reasons, women remain in the abusive relationship because of fear and economic dependence (Ramsay, 1995; Songca & Letseku, 1998).

Although there are laws prohibiting domestic violence and rape, violence against women often occurs anyway. It has been argued that women need more than law reform, as legal changes must be accompanied by ideological and cultural changes (Songca & Letseku, 1998).

Whether sexual violence is inflicted by strangers or intimate partners, the fact remains that violence increases women's risk of exposure to HIV and other STDs. How can women be expected to negotiate safe sex in a culture of gender violence!

The Unfavourable Economic Position of Women

Another factor that can put women at risk is their poor economic position (Strebel, 1993). The ongoing economic crises in Africa have worsened the employment situation for women and men alike. However, women face even greater vulnerabilities in the labour market due to their relative lack of education and training. In addition to this, the continuous heavy burdens of unpaid domestic work, child bearing, and child care restricts the time and energy available for income earning activities (Manuh, 1998).

It has been estimated that women head about 31% of households in urban and rural areas across Africa, often with no working resident males (Manuh, 1998). Because of the decline of national and local economies and the migration of men to cities, many men have been unable or unwilling to contribute their share toward household expenses. This has increased the number of women living in poverty and the number of households in the poorest categories headed by women.

With increasing pressure on them, women are forced to find some means of supplementing their economic situation to attain some measure of autonomy and self-reliance. In this regard, Basset (1993) argues that the number of women who sell or barter sex at one time or another is larger than we think. Very often women involved are divorced mothers who have children to support and for whom remarriage is an unlikely prospect. Add to this many rural (often unskilled) women forced by drought and widespread crop failures to migrate to the cities in a bid to support their families and the young, unemployed women with no real future prospects due the poor economic conditions in the country.

The predicament for many of these women is straightforward. Sex is a strategy for survival, with women selling sex to meet specific obligations, such as paying school fees or buying food. These transactions cover all sorts of arrangements, many of which are not socially considered prostitution (Basset, 1993). Reward for sexual services may range from occasional cash payments to supplementation of income with gifts.

Many young girls who have financial problems exchange sex for money to buy the basics such as soap and food, and some even use this money to pay for their education. Relationships are contractual in nature, with the girls expected to be available in exchange for presents of money, clothes, and food. One participant in the study of Mwale and Burnard (1992) put it in a nutshell when she commented: "They are not looking for the disease and they are looking for money ... that's the big problem and in looking for money, they acquire the disease" (p. 38).

Most women dependent on trading of sex would seize viable alternatives. Female poverty can be regarded as a threat to the well-being of women, particularly as it encourages behaviour that increases the risk of HIV infection.

Male Control of Sexuality

Another important factor that puts women at risk is male control over sexuality or, conversely stated, the lack of female control over sexual matters. Often women have little bargaining power to negotiate safe sex with their partners and few have control over the sexual behaviour of their partners. In the study conducted by Wood and colleagues (1997), a girl explained, "As a woman you have no rights, you must keep quiet and do as the man wants" (p. 23). Women are generally aware of the power inequalities and double standards operating within constructions of love and sex, but they find that resistance is difficult because of male violence and cultural norms and expectations.

Two facets of male control of sexuality will be discussed: (a) women's lack of control over the sexual lives of their partners and (b) the inability of women to insist on the use of condoms.

Women's Lack of Control over the Sexual Lives of Their Partners

For many South African women the threat of HIV infection begins with a lack of control over the sexual lives of their partners. For wives the danger lies in their husband's sexual relationships outside marriage.

Traditionally a man's need for sex and the right to more than one partner have been sanctioned/accepted in many African cultures.[3] Usually the family arranged these sexual partnerships. In traditional society, for example a man could have more than one wife only if his wealth permitted. This requirement limited polygamy to those able to maintain additional households. However, urbanization and modernization have changed the organization of sexual partnerships, and what has emerged is a sexual structure allowing mistresses and love affairs. This configuration of relationships has led to the rampant spread of STDs including AIDS (Basset, 1993; Mwale & Burnard, 1992).

Yet, although they are aware of the fact that their husbands are not monogamous, women feel powerless to change the situation and in most cases accept it. Thus encouraging women to be monogamous does not eliminate the threat of HIV infection, as often it is the husband who is not monogamous. In this regard a female participant in the study of Mwale and Burnard (1992) stated: "I am married and I respect myself and I don't have extra marital affairs ... but then you find that men still have affairs so we are still at risk" (p. 55). It is unlikely that men have protected sex in their extramarital affairs, which in turn puts their wives at risk.

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[3] About 50% of women in Africa are married by age 18, and one in three women is in a polygamous marriage (Manuh, 1998).

The Inability of Women to Insist on Condom Usage

Many studies have been conducted regarding condom usage (Pesa, Syre, & Fu, 1999; Sankar & Karim, 1999; Warren, 1997). Women are generally more positive toward the use of condoms than men, as they believe it will protect them from STDs. The negativity of men toward condoms revolves around two issues. The first is physical: Men claim that condoms reduce pleasure. The second is attitudinal: The perception exists that only prostitutes use condoms. If a woman suggests the use of a condom, she may be accused of being unfaithful or hiding an STD. In addition, it appears that men feel insulted if a condom is suggested, as it casts doubts on their faithfulness (Schoepf, 1988).

Combined with this male negativity there exists an inability of women to insist on condom usage due to their lack of power in interpersonal relationships and because of a lack of communication regarding sexual matters. "How do I tell my husband to use a condom?" asked one participant in a study by Oliver (1996; p. 322). Another admitted that she had talked about condom use with her husband and he promptly called her a prostitute.

Also in the area of sex work, the use of condoms is resisted. In a study among South African prostitutes Karim and Karim (1995) found that clients were more likely to behave aggressively when condoms were used or suggested, which made the women fearful of suggesting their use. The same study revealed that although condoms were obtained from government clinics they were used infrequently. Some prostitutes never asked clients to use condoms and of those who did most of the time the clients refused. Also relevant is that they reported that condom use led to physical abuse by clients. Clients insisted on paying less for sex when a condom was used. The women who insisted on condom use charged only one quarter of the average price. With economic pressure on women they are less likely to opt for the "safe" option if it means a substantial loss in income.

CONCLUDING COMMENTS

Any efforts to stem the HIV pandemic in South Africa must acknowledge the social factors that make women vulnerable to HIV infection. In this context, it is important to realise that AIDS prevention strategies that promote (a) the condom as a simple protection device (based on the assumption that women have control over their sexuality, which currently they do not) and (b) monogamy (based on the assumption that women can control the sexual activities of their partners) may not be effective as they fail to take into account the reality of the daily lives of South African women. Changing the power imbalance that currently exists in the relationships between men and women is perhaps one of the most important challenges facing AIDS prevention in South Africa, as only then will women have the power to protect themselves.

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